ABSTRACT

SOCIAL WORK

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A COMPARATIVE ANALYSIS OF YOUTH CARE WORKERS PERCEPTION OF RESTRAINT AND SECLUSION AS AN INTERVENTIVE STRATEGY AMONG ADOLESCENTS IN RESIDENTIAL TREATMENT FACILITIES AND THE EFFECTS THEY HAVE ON JOB SATISFACTION.

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The overall objective of this study is to provide insight on Youth Care Workers perception of restraint and seclusion as interventive techniques and if the use or non-uses of those techniques affect the workers job satisfaction. The study used 29 respondents, ages 22 to 42 both male and female in which some used restraint and seclusion techniques and the others did not. To obtain the findings, comparative analyses of several variables were observed such as; workers perceived satisfaction with their job, workers job satisfaction, workers perception of restraints, and workers perception of seclusion. In addition it is exploratory in that the results will provide important baseline information regarding Youth Care Workers perception of restraint and seclusion as interventive strategies among adolescents in residential treatment facilities.

A self-administered questionnaire was given to Youth Care Workers that work at a facility that uses restraint and seclusion techniques and facility that does not use restraint and seclusion techniques. The questionnaire consisted of forty-three questions that addressed Youth Care Workers perception of restraint, seclusion, job satisfaction and level of job satisfaction.

The study hypothesis stated that there would be a significant difference between Youth Care Workers perception of the use and non-use of restraint and seclusion as interventive strategies among adolescents in residential treatment facilities and the effects of the use or non-use on job satisfaction. This study hypothesis was rejected because the results revealed that according to the responses of the respondents, there was no significant difference in the Youth Care Workers perception of restraints, perception of seclusion, perception of job satisfaction or level of job satisfaction. Due to the small sample of respondents, a significant difference was difficult to establish. However, there is room for further research regarding restraint and seclusion and the effects these interventive techniques may have on job satisfaction.

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CHAPTER ONE

INTRODUCTION

As a frustrated and concerned Youth Care Worker employed at two local residential treatment facilities that serve youth with varying emotional problems, and delinquent behavioral problems, this researcher was interested in understanding the behavioral control and management strategies utilized by both facilities. The displaying of unruly behavior by the adolescents influenced these researchers' interest in the available techniques used to manage residents' behavior. This researcher has taken part in an environment that utilizes non-violent therapeutic management, in the form of restraint and seclusion, and an environment that does not utilize any form of management. Note that the term's "intervention" and "management" are being used interchangeably in this study. This researcher has had the opportunity to see both sides of the spectrum, in regards to non-violent therapeutic management, no type of therapeutic management, and the effects the use and non-use of therapeutic management has on the varying workers.

When working at the facility that uses restraint and seclusion on "out of control" residents, this researcher felt more comfortable knowing that interventive strategies were available to protect oneself and others. On the other had, this researcher has also been in compromising situations at the facility that does not utilize restraint and seclusion, and

remembers experiencing the feeling of vulnerability. Vulnerability, being defined as unsafe and in jeopardy of being harmed. When speaking with other colleagues that work at the facility that does not utilize restraint and seclusion, it was found that the feeling of vulnerability was present in other YCW's as well as this researcher.

This researcher feels that the residents at the facility that does not utilize restraint and seclusion challenge the authority of the YCW's more frequently than the residents that live at the facility that does use restraint and seclusion. There is no statistical data that supports these observations, but this researcher feels this behavior is due to the resident's awareness of the YCW's limits as far as intervening. This researcher also found that the turn over rate at the facility that does not utilize restraint and seclusion is much higher than the turn over rate at the facility that does utilize restraint and seclusion. The statistical reasoning behind the higher rates of turn over is not available for this study; it is merely an observation by the researcher.

This issue prompted the idea for this comparative analysis study of Youth Care Workers job satisfaction and perception of the use and non-use of restraint and seclusion on the residents that they serve.

Restraint and seclusion are precautions that are taken to ensure safety and to avoid physical or property damage. Because adolescents are placed in these facilities for various reasons, workers may finds themselves confronted with children struggling with emotional abuse, physical abuse, neglect, abandonment, emotional disorders, and psychological disorders. A large number of the adolescents placed in residential treatment facilities, have trouble managing their anger and frequently display

inappropriate behavior.[1] Some forms of anger mismanagement are; shouting, cursing, fighting, running away, property damage, and self-harm.

Verbal aggression is common and can often be managed by using de-escalation techniques. However, when residents engage in fighting, self harm and property damage, more immediate crisis intervention is necessary.

The field of health/mental health is stressful within itself, but when safety becomes an issue, precautions should be taken.[2] It seems that job safety or the lack of it ultimately affects the workers feelings about their job. Job satisfaction is a major determinate of how productive and effective a program is.

This researcher also felt that it was very important for YCW's to have a degree of control over all crisis situations that take place in the residential treatment facilities. It is fundamental that YCW's are comfortable demonstrating techniques, whether they are verbal or physical, that will bring things back to order.

Non-violent crisis management may not be the answer to all situations, but it is up to the facility to determine what interventive technique is best for the population that they serve. Literature has suggested that the use of restraints should be contingent upon the emotional and physical history of the child it is being used on. Therapeutic restraints may not be appropriate for children who have undergone sexual, physical, or traumatic emotional abuse, because the very act may rekindle undesired memories that are more

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[1] Richard Small, Ph.D., Kevin Kennedy, D.S.W., and Barbara Bender, M.S.W., "Critical Issues For Practice in Residential Treatment: The View from Within," American Journal of Orthopsychiatry 61(3) (July 1991) p. 328.

[2] Nancy S. Cotton, Ph.D., "The Developmental-Clinical Rationale For the Use of Seclusion in the Psychiatric Treatment of Children," *American Journal of Orthopsychiatry* 59(3) (July 1989) p. 442.

harmful than helpful. It is important to remember that the key word to therapeutic management is "therapeutic".

For other residents, therapeutic management is not only helpful, but also necessary. The main purpose of therapeutic management is to bring a "out of control" situation back into control. It should not be used for punishment or loosely in any sense. It should be used as the last resort after all other interventive resources have been exhausted.[3]

This study is relevant for the Social Work profession because there appears to be limited social work research on restraint and seclusion. It is imperative that the Social Work knowledge base is expanded to explore whether further usage of restraint and seclusion in setting that service children is effective or ineffective and whether the use or non-use affect workers job satisfaction. It is also important that social workers stay abreast on the most effective intervention techniques, considering that a large portion of our profession focuses on preventive and interventive clinical strategies.

Statement of the Problem

The presenting problem addressed in this study is Youth Care Worker perception of restraint and seclusion as an interventive strategy among adolescents in residential treatment facilities and the effects they have on job satisfaction. As mentioned earlier, a

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[3] Howard Bath, "The Physical Restraint of Children: Is it Therapeutic?," *American Journal of Orthopsychiatry* 64(1) (January 1994), p. 42.

large number of these children suffer from varying emotional and psychological disorders. However, emotional and behavioral disorders are more prevalent in this population of adolescents. They come to residential treatment facilities with emotional and physical scars that sometimes inhibit their ability to express their feelings appropriately.

Needless to say, that with the increase of residential treatment facilities brings the need for more YCW's or people who provide direct care to these children. Although the ratio of children to YCW's is high, there is still a need for a large number of YCW's when viewing the wide spectrum of care.

When children come to these facilities lacking the ability to manage their anger and behavior, some form of interventive technique must be in place to regulate these behaviors.

Interventive techniques vary according to the modality that the facility follows and the population of children the facility is caring for. Some places choose to use crisis interventive techniques while others do not.

The facility that is properly trained in utilizing non-violent crisis interventive techniques record that their confidence in the job and ability to intervene in crisis situations increased by 98%.[4]

On the other hand, the lack of crisis intervention may present the problem of "out of control" children that ultimately results in an unpleasant and unsafe working

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[4] National Crisis Intervention Institute, "Are You and Your Staff Prepared For a Potentially Violent Episode?," *Violence and Crisis Intervention* October 1995 [article on-line]; available from http://www.execpc.com/~cpi/mhweb.html; Internet; accessed 20 January 1998 p. 2.

environment. The lack of control and constant verbal and physical abuse by the residents can be very stressful for the YCW. It can be equally distressful for the colleagues of the YCW that is being directly affected by these unruly children.

With the environment being unsafe and unpleasant, the issue of low job satisfaction and high employee turn over may present to be a problem for the agency. Low job satisfaction is one of the leading reasons for high employee turn over rates for child and youth care staff at residential treatment centers.

In order for there to be effective treatment and a safe environment for both the worker and the child, appropriate non-violent interventive techniques must be implemented which ultimately may create a more desirable work environment.

Purpose of the Study/Significance of the Study

This study is attempting to help expand the current body of literature that exists on YCW's perception of restraint and seclusion as an interventive strategy among adolescents in residential treatment facilities and the effects they have on job satisfaction.

Studies show that care professionals who correctly use non-violent crisis intervention techniques reduce the occurrence of physically assaultive incidents at the work place and inadvertently create a safer, calmer environment for clients and staff alike.[5] However, there has been no evidence of a published study that addresses the

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[5] Ibid.

relationship between the usage and non-usage of restraint and seclusion in residential treatment facilities and their affects on job satisfaction.

This subject is of importance to the Social Work profession because Social Workers generally work closely with adolescents who reside in residential treatment facilities. In many instances, the Social Worker's role is to process with the residents on concerns they may have about their treatment or life situations. If restraint and seclusion are more harmful than helpful, it is the Social Workers responsibility to advocate for change in the intervention techniques being used.

The findings from this study may provide insight for the Social Work Profession. It may also generate information that will be invaluable, with respect to setting up programs that are tailored for effective care of adolescents. The results may also be valuable to directors of these programs when establishing a modality for a facility that serves adolescents. Supervisors may find the study insightful in terms of what is appropriate, effective, and executable. It may address issues regarding YCW's comfort level in administering these techniques and if the execution or non-execution of these techniques is affecting the workers job satisfaction independently.

The significance of this study is to provide information that might lead to more efficient strategies for intervention (e.g. restraint and seclusion). Additionally, significant aspects relates to the need to gather the necessary data to identify the elements that contribute to job satisfaction, use or non-use of restraint and seclusion and for forming the objectives of Youth Care Workers. This study is also significant because there appears to be a gap in knowledge pertaining to restraint and seclusion on the Social Work level. It is important that the profession of Social Work stays abreast on issues that

address every population especially issues that are controversial, affecting the quality of human life.

It is imperative that the Social Work profession follows this form of intervention very closely to ensure that this technique is in the best interest of the adolescent.

CHAPTER TWO

LITERATURE REVIEW

As mentioned earlier there was limited literature found on the relationship between restraint and seclusion as interventive techniques as they relate to job satisfaction. However the literature does give fairly extensive evidence from researchers that restraint and seclusion are effective if used properly.[1]

As to if a significant relationship exists between the Youth Care Workers perception of restraint and seclusion as an interventive strategy among adolescents in residential treatment facilities and the effects they have on job satisfaction, little is known. The researcher, however, has gathered evidence that indicates the proper training in the usage of restraint and seclusion and proper implementation of restraint and seclusion, raises the confidence and moral of the social service workers.[2] Studies have also shown that when the feeling of satisfaction is present in the workplace, productivity and customer service is increased.[3]

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[1] William A. Fisher, M.D., "Restraint and Seclusion: A Review of the Literature," *American Journal of Psychiatry* 151(11) (November 1994), p. 1584.

[2] Ibid., p. 1589.

[3] Srinika Jayaratne, and Wayne A. Chess, "Job Satisfaction, Burnout, and Turnover: A National Study," *Social Work* 29 (September -October 1984) p. 449.

The use of restraint and seclusion can be dated back almost 200 years. The forerunner of the research was Philippe Pinel who described the basic principles of restraint and seclusion as the balance between safety and patients' rights.[4]

Although, his philosophy is dated, it appears to be the foundation of many, if not all, organizations that utilize methods of seclusion and restraint.

Most of the literature was presented as "restraint and seclusion," however, the limited literature that addressed the variables seclusion and restraint independently will be presented as such.

Seclusion

In an article written by Nancy Cotton in 1995 entitled "Seclusion as a Therapeutic Management: An invited Commentary,"[5] modification of socialization strategies used in normal child rearing was addressed. The aim was to use these with youth for whom such approaches have not worked or have been too little and too late. She explains how seclusion can be therapeutic if used correctly and that therapeutic management can be used for both control and treatment, along with other active containing interventions (e.g., physical holding and restraints). Cotton feels adamant about seclusion being viewed in the context of the child's abilities, despite psychiatric illnesses or psychosocial

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[4] Ibid., p. 1584.

[5] Nancy S. Cotton, Ph.D., "Seclusion as Therapeutic Management: An Invited Commentary," *American Journal of Orthopsychiatry* 65(2) (April 1995) p. 245-248.

vulnerabilities, to engage in adult-child interaction that lead to therapeutic gains and developmental progress.[6]

On the other hand, Irwin saw seclusion rooms as unnecessary on child psychiatric units with adequate staffing. He felt that staff members should be able to control the actions of the child without touching or seclusion.[7]

Restraint

An article was written in 1989 by Dale Barlow, B.S.N., and M.H.D., on the use of Therapeutic Holding. This article discussed the effectiveness of this type of intervention when caring for aggressive children. He theorized about the need to restrain children who are out of control, but he also stressed the therapeutic processing that takes place after an outburst has occurred. Barlow asserts that children should be required to process either verbally or in writing the feelings associated with the aggressive act with an emphasis on alternative ways of expressing intense feelings.[8] He also noted that consideration should be given for the negative impact that aggression has on nursing personnel. Proper education and attention to detail can minimize potential harm to self, others, and clients. He reported that this can be accomplished through unified training of the staff members on the proper way to administer therapeutic holding. In conclusion,

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[6] Ibid.

[7] William A. Fisher, M.D., "Restraint and Seclusion: A Review of the Literature," *American Journal of Psychiatry* 151(11) (November 1994) p. 1585.

[8] Dale J. Barlow, B.S.N., M.H.D., "Therapeutic Holding," *Journal of Psychosocial Nursing* 27(1) (1989) p. 10-14.

Barlow expressed that therapeutic holding is a technique that can be used successfully to decrease aggression in children.

In 1997 the American Academy of Pediatrics formed a policy regarding the use of physical restraints. Policy RE9713, The Use of Physical Restraint Interventions for Children and Adolescents in the Acute Care Setting states that:

> Children and adolescents may need to be physically or chemically restrained for various procedures, because of disruptive behavior, or to prevent injury to themselves or others. The use of restraint for a child or adolescent required clear indications, safe application, reassessment guidelines, and use only after the consideration of alternative methods. Seclusion refers to the involuntary confinement of a patient alone in a room, from which the patient is physically prevented form leaving, for any period of time.[9]

They support the fact that restraints and seclusion may need to be used, but only under certain guidelines and clear indicators.

In some instances, like a study conducted by Howard Bath, Ph.D., the researcher supports one variable yet rejects the other. His journal, "The Physical Restraint of Children: Is It Therapeutic?" was written in 1994.[10] This article discussed the appropriate use of restraint and how seclusion may not be as therapeutic as physical restraint or therapeutic holding. He maintained that "despite the reactions of distaste that we feel for such measures, physical restraint may be the most legally appropriate and ethically sound method of protecting the dangerous child from harm."

Bath also found that physically restrained adolescents appeared to calm down and resume normal activities more quickly than those who had been secluded. This was due

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[9] American Academy of Pediatrics, "The Use of Physical Restraint Interventions for Children and Adolescents in the Acute Care Setting (RE9713)," *Pediatrics* 99 (March 1997), p. 330-335.

[10] Howard Bath, Ph.D., "The Physical Restraint of Children: Is It Therapeutic?," *American Journal of Orthopsychiatry* 64(1) (January 1994) p. 40-49.

to the verbal processing that takes place when a child is being restrained. Unlike the act of seclusion, the child is virtually by him/herself the entire time with no means of processing the incident that previously occurred. He identified several factors regarding seclusion, but the most prevalent is the possibility that seclusion will reinforce the deep anxieties experienced by the many disturbed children because of the rejection or exclusion inherent in the act of seclusion.

> Bath also took a close look at the affects the act of administering physical restraints has on the youth care workers. He felt that emotional stress on the workers might be of greater concern than the physical. Additional difficulties lie in the distaste most care workers express at having to intervene physically with children. In the troubling contertherapeutic techniques emotions such as episode may arouse, in uncertainty over the rights course of action, and in guilt at having perhaps inadvertently contributed to the eruption of the crisis or responded too firmly.

Former childcare workers have pointed out that emotional issues surrounding the management of aggression cause the greatest stress among child and youth care workers and no doubt contribute to the high burnout rates in the field.

Crisis Prevention Institute (CPI) conducted a study on the effectiveness of there non-violent intervention techniques. CPI trains professional workers in identifying violent behavior, defusing potentially violent situations, and performing physical restraint techniques when residents become physically assaultive.[11] They surveyed 1,200 facilities that used the CPI training and the results indicated that 77% reported a reduction in the number of assaultive incidents, 69% saw a reduction in workers' compensation claims, and 98% reported an increase in staff confidence.[12]

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[11] Ibid. p. 1.

[12] Ibid., p. 2.

Contrary to the former literature, Derek Miller, M.D., Mark C. Walker, M.D., and Diane Friedman, R.N. conducted a study on the "Use of a Holding Technique to Control the Violent Behavior of Seriously Disturbed Adolescents"[13] which focused on therapeutic holding. The effectiveness of holding was assessed on a 26-bed tertiary care inpatient adolescent psychiatric unit at a university hospital. The only screening policy is not to admit adolescents know to be grossly intellectually defective, physically handicapped, or brain-injured. Adolescents with serious emotional and behavioral difficulties were admitted.

The adolescent treatment program provides two kinds of care. The first was nonspecific care, which is required by all adolescents for normative emotional and physical development. The second was specific care, which was especially designed to address the need of individual patients, including appropriate biological intervention for underlying psychotic or affective disorders and other disturbances. The finding suggested that over the 18-month period, 40 patients in the total population of 175 patients required therapeutic holding at least once. The 135 patients who did not require holding constituted a reference group. Twenty-one of the 40 patients required this intervention only once. A total of 112 episodes of therapeutic holding were recorded and examined. The median length of the interventions was 15 minutes, and the mean length was 21±16.98 minutes, with a range of one to 90 minutes.

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[13] Derek Miller, M.D., Mark C. Walker, M.d., and Diane Friedman, R.N., "Use of a Holding Technique to Control the Violent Behavior of Seriously Disturbed Adolescents," *Hospital and Community Psychiatry* 40(5) (May 1989), p. 520-524.

The study concluded that in reasonably planned treatment that is developmentally based and that takes a non-specific approach regarding needs, non-human physical restraints and isolation do not seem necessary to control violence in adolescent inpatients. It also concluded that staff time and staff manpower required to perform therapeutic holding appear reasonable and predictable, although consistent staff training and supervision are necessary for therapeutic holding to be successful.

The Professional Crisis Management Association (PCMA), which is another non violent crisis intervention program, has feeling similar to Miller, Walker and Friedman in the respect that they do not feel restraints are necessary. They promote a non-violent crisis intervention technique also, but there is never any physical contact. PCMA relies solely on verbal de-escalation and preventive measures. They believe that if a situation gets to the point of physical assaultiveness, the worker somehow did not react appropriately.[14]

On the other hand, some researchers were interested in early intervention and regulating the use of these techniques.

Toby J. Measham, M.D., wrote a journal article on "The Acute Management of Aggressive Behaviour in Hospitalized Children and Adolescents."[15] He was examining how health care professionals attempt to manage acutely aggressive behaviors that are exhibited by children and adolescents in hospital settings. He concluded that the early

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[14] Professional Crisis Management Association, "Professional Crisis Management Highlights," System Highlights November 1997 [article on-line], Available from http://www/profcris.com/~pcma/mhweb.html; Internet; accessed 28 January 1998.

[15] Toby J. Measham, M.D., "The Acute Management of Aggressive Behaviour in Hospitalized Children and Adolescents," *Canadian Journal of Psychiatry* 40 (August 1995), p. 330.

identification of such factors might provide an opportunity to design individual treatment plans that can decrease and manage the occurrence of aggression. The studies reviewed in this paper do not provide evidence for the advantage of one acute management strategy over another, apart from the efficacy of time-out procedures. He felt that there are presently no studies that compare the different management techniques. There is clearly an urgent need for such work.

He also cautions that if an acutely dangerous situation exists, which does not respond to the previously outlined interventions, restrictive management strategies such as restraints may be necessary.[16]

In 1994 Natalie Grizenko, M.D., F.R.C.P.(C), and Nicole Pawliuk, M.A., conducted a study on "Risk and Protective Factors for Disruptive Behavior Disorders in Children".[17] The population consisted of children with disruptive behavior-disorders which consisted of 26 boys and 24 girls, mean age nine years (SD = 2.1), with severe behavior problems as determined by total scores at least 70 on the Revised Child Behavior Profile. The matched control group was recruited from five summer day camps in the Montreal area. It included children aged 6-12 whose parents consented to their participation, and who had a total Revised Child Behavior Profile score below 70 (not in the problem range). The group consisted of 24 boys and 26 girls with the mean age of 8.3 years (SD = 8.2). All variables were categorized as biological, psychological, or

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[16] Ibid., p. 335.

[17] Natalie Grizenko, M.D., F.R.C.P., and Nicole Pawliuk, M.A., "Risk and Protective Factors For Disruptive Behavior Disorders in Children," *American Journal of Orthopsychiatry* 64(4) (October 1994) p. 534-542.

social risk factors or biological, psychological, or social protective factors, thus yielding six subgroups. The study found that risk and protective factors that significantly discriminate between behavior problem and control children were examined. The biological factors placing children at risk for the development of disruptive behavior disorders included hyperactivity as an infant, learning disabilities, school failure and prenatal complications, and a history of maternal depression.

It also found that psychological risk factors associated with disruptive behavior disorders included negative personality traits (e.g., jealousy, anxiety, clinging to parents, and needing to be the center of attention), and a history of frequent punishment and emotional neglect.

Significant protective factors were defined as those associated with a reduced risk of behavior disorder under conditions of recent high stress. The social protective factors that significantly discriminated between behavior-problem and control children were having two or more hobbies and a positive relationship with grandparents.

The importance of identifying risk factors early is to maybe curtail negative behavior early on so that this population of children will not be subjected to institutionalization that may at some point attempt to deal with these behavior disorder with corporate type intervention techniques.

Louise Murray and Gary Sefchik wrote an in-depth article entitled "Regulating Behavior Management Practices in Residential Treatment Facilities. This article addressed the need for regulation of discipline/behavior management practices that are utilized in the treatment of emotionally disturbed youth in residential facilities. They

approached the topic from the licensing perspective. They were concerned that some regulating interventions may compromise or violate the rights of these youth and that the licensing board should look closer at the population of "disturbed" youth regarding whether these practices are helpful or harmful. Similar to the perspective of Miller, Walker and Friedman; Murry and Sefchik takes the stance that this type of management can be deemed corporate and unjustified and they felt that restraints were unnecessary. Their philosophy differs in the respect that Murry and Sefchik argued that restraints should be utilized when a child is trying to harm himself/herself or others.[18]

Ultimately, Murry and Sefchik suggested that licensing inspectors need to maintain current and accurate assessment of these behavior management practices and to develop rules governing these practices that are based on a rational assessment of what is effective. At same time, licensing boards should work to preserves the safety, well being and emotional development of these youth.[19]

Seclusion and Restraint

In a journal entitled "Seclusion as Therapeutic Management: An Invited Commentary", which was written in 1995, Nancy Cotton discussed the effectiveness of restraint and seclusion.

> She pointed to the positive behavioral outcomes of the appropriate use of seclusion and restraints in the psychiatric treatment of children as a part of a program of therapeutic management aimed at stopping maladaptive behaviors, developing adaptive behaviors, and safely re-channeling

[18] Louise Murray and Gary Sefchik, "Regulating Behavior Management Practices in Residential Treatment Facilities." *Children and Youth Services Review,* 14 (1992), p. 519-539.

[19] Ibid.

> affects and impulses. She also stated that, when used in a manner consistent with the clinical-developmental needs of the child, seclusion and restrain could enhance safety and demonstrate adult caring.[20]

American Psychiatric Association (APA), provided literature that supports their belief that verbal de-escalation and medication, seclusion and restraint are techniques used to control violent behavior. They expressed that the decision to use restraint and seclusion should be based on individual cases and situations only. The clinician should exercise reasonable clinical judgment rather than depend on the use of rigid regulation, statues or checklists.[21] APA also stated that in some cases restraint might be preferred more than seclusion because the situation may require close monitoring.[22]

In a1989 study entitled "Impact of Therapeutic Management on Use of seclusion and Restraint with Disruptive Adolescent Inpatients"[23] a convenience study of three inpatient adolescent psychiatric units were examined during two five-month periods before and after implementation of a "therapeutic management" protocol.

> Under the protocol, staff classified disruptive behaviors into four stages and provided verbal and behavioral intervention to control behavior at each stage. Changes between the study periods in the number of voluntary and involuntary patients requiring seclusion and restraint were also assessed, as were changes in patient-to staff ratio, age, sex, and racial distribution of patients requiring seclusion and restraint, and use of medication to control aggression. Percentages for

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[20] Nancy S. Cotton, Ph.D., "The Developmental-Clinical Rationale for the Use of Restraint and Seclusion in the Psychiatric Treatment of Children," *American Journal of Orthopsychiatry* 59 (April 1989) p. 442-450.

[21] American Psychiatric Association, "APA Task Force Reports," APA Online Library & Publications [article on-line]; available from http://www.psych.org/libr_publ/taskforce_rprt4.html; Internet; accessed 27 January 1998 p. 2-3.

[22] Ibid.

[23] Ikar J. Kalogjera, M.D., Ashok Bedi, M.D., D.P.M., R.C.P.S. (Eng.), M.R.C.Psych. (U.K.), William N. Watson, M.D., and Anthony D. Meyer, M.D., "Impact of Therapeutic Management on Use of Seclusion and Restraint with Disruptive Adolescent Inpatients," *Hospital and Community Psychiatry* 40(3) (March 1989) p. 280.

each variable were compared using chi square analysis. T tests were also used to compare data on all variables except voluntary or involuntary status.[24]

The results found that the no significant differences were found in the age, sex, or racial distribution of patients requiring seclusion and restraint before and after the protocol was adopted. It also showed that the use of seclusion and restraint did not vary between the three wards or between shifts (morning, evening, and night) or day of the week on the same ward. No significant differences were found in the use of medication before, during, or after the seclusion episodes during the two study periods.[25]

An article written by Tony D. Crespi in 1990, on "Restraint and Seclusion with Institutionalized Adolescents," examines the population of adolescents who are exposed to such procedures as restraint and seclusion and the implication within these settings. Crespi observed that the use of restraint and seclusionary procedures within both the psychiatric hospital setting and the criminal justice system is cause for concern.[26] He states that at the present time there is evidence that some two million young people either witness or are directly exposed to these interventions. He concludes that the children are clearly affected by these techniques as well as the institutions personnel and families.

Job Satisfaction

In 1991, a study was conducted by Jacob Wolpin, Ronald J. Burke, and Esther R. Greenglass, entitled "Is Job Satisfaction an Antecedent or a Consequence of

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[24] Ibid., p. 283.

[25] Ibid., p. 284.

[26] Tony D. Crespi, "Restraint and Seclusion with Institutionalized Adolescents," *Adolescence* 25(100) (Winter 1990), p. 825-828.

Psychological Burnout?".[27] This study examines the relationship between job satisfaction and burnout. The data was collected from 245 school-based educators from a single Board of Education. The variables were work settings characteristics, sources of stress, psychological burnout, and job satisfaction. The results showed that negative work setting characteristics and marital dissatisfaction were associated with greater work stressors, which in turn were associated with increased burnout, which in turn resulted in decreased job satisfaction. When the longitudinal design was employed, psychological burnout appeared to have a causal relationship to job satisfaction, not vice versa.

Another supportive study was conducted by Robert J. Drummond and Ann Stoddard in 1991 entitled "Job Satisfaction and Work Values". The purpose of the study was to examine the relationship of work values to job satisfaction. The sample was taken from 69 graduate and undergraduate female education majors working in the helping professions. They were administered the Work Values Scale and the Minnesota Job Satisfaction Scale. The results indicated that there was a significant correlation at the .05 level between each of the four scales of the Work Values Inventory with general job satisfaction. The variables were variety, economic returns, security, creativity, and management. These correlations were negative, indicating a tendency for an inverse relationship between job satisfaction and the five values.

Srinika Jayaratne and Wayne A. Chess conducted a study entitled, Job Satisfaction, Burnout, and Turnover: A National Study, which addressed the levels of job

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[27] Jacob Wolpin, Ronald J. Burke, and Esther R. Greenglass, "Is Job Satisfaction an Antecedent or a Consequence of Psychological Burnout?," *Human Relations* 44(2) (1991), p. 193-206.

satisfaction, burnout, and intent to change jobs among child welfare, community mental health, and family service workers. The variables in this study were stress, physical comfort, challenge, financial rewards, and promotional opportunities as indicators of organizational climate. The author noted that those variables were not generally associated with burnout, although there appears to be some relationship between them and job satisfaction. The study consisted of 288 participants. 144 participants were from community mental health, 60 were from child welfare, and 84 were from family services. The results indicated that family service workers perceived a much better work environment than those reported by their colleagues in community mental health and child welfare. The family service workers recorded the best scores-with respect to a positive work environment-on seven of ten indexes: depersonalization, role ambiguity, value conflict, work load, comfort, challenge, and role conflict.[28]

An established researcher by the name of Diane Vinokur-Kaplan conducted a study entitled, "Job Satisfaction Among Social Workers in Public and Voluntary Child Welfare Agencies."[29] The sample consisted of 413 social workers that were presently employed in a realm of social work, 77% of the participants were female and 23% were male. The variable that was measured for this study was job satisfaction. The findings indicated that there was no difference in job satisfaction according to whether the graduate had finished a baccalaureate or M.S.W. program. However, the study

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[28]Srinika Jayaratne and Wayne A. Chess, "Job Satisfaction, Burnout, and Turnover: A National Survey," *Social Work* 39(5) (September-October 1984) p. 448-453.

[29] Diane Vinokur-Kaplan, "Job Satisfaction Among Social Workers in Public and Voluntary Child Welfare Agencies," *Child Welfare* 70(1) (January-February 1991), p. 81-91.

conducted by Jayaratne and Chess, noted that there was a significant difference in average job satisfaction according to job location. Those respondents working in child welfare and child welfare-related agencies were the most satisfied, while those in other social work agencies were less satisfied.

In research that was done on "Client and Worker Satisfaction in a Child Protection Agency"[30], the researchers aimed to understand worker satisfaction in a child protection agency. The variables were physical conditions, relations with co-workers, autonomy, pay, promotion opportunities, and industrial relations. Interviews and standard questionnaires were used to gather information. Twenty-four clients were used and twenty-one agency staff members were used. The results indicated that the workers were able to relate empathetically to clients and felt enthusiasm for the work. Taking into account the possible bias in both sets of answers, there is still evidence that the agency is succeeding in creating a necessary precondition for therapeutic change: the development of accepting and positive worker -client relationships.

Another study entitled "Relation Among Measures of Burnout, Job Satisfaction, and Role Dynamics for a Sample of South African Child-Care Social Workers"[31], proceeded to understand if there was a relationship among measures of burnout, job satisfaction and role dynamics. The sample was made up of twenty-nine female childcare social workers with an age range of 23 to 56. The variables being measured were

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[30] Helen R. Winefield and Jillian A. Barlow, "Client and Worker Satisfaction in a Child Protection Agency," *Child Abuse and Neglect* 19(8) (1995), p. 897-905.

[31] Arvin Bhana and Nasrin Haffejee, "Relation Among Measures of Burnout, Job Satisfaction, and Role Dynamics for a Sample of South African Child-Care Social Workers," *Psychological Reports* 70 (1996), p. 431- 434.

emotional exhaustion, depersonalization and personal accomplishments. The results established that frequency burnout was 62%, experienced moderate emotional exhaustion was 14%, 93% experienced moderate intensity of depersonalization and 86% experienced high frequency of burnout.

"Social Structure, Burnout, and Job Satisfaction, was a study that was conducted by Joan Arches in 1991.[32] This study was initiated to understand burnout and job satisfaction. The sample consisted of two hundred seventy-five randomly selected social workers that were practicing in Massachusetts in 1988. The variables were sociodemographic data, organizational data, autonomy, bureaucracy, organizational supports, and social supports. The findings indicated that 28% of the total explained variance in burnout, with the only significant variables being perception of autonomy and funding source influence. The only significant variable was perception of autonomy.

Theoretical Framework

This study takes an eclectic approach utilizing Behavioral theory, Environmental theory and Crisis theory. The eclectic framework espouses the thought that no one theoretical framework is sufficiently comprehensive in order to meet the multi complex problems of today's client. An eclectic practitioner addresses the models and theories that best matches a given problem situation using techniques that have been demonstrated to be effective and sufficient.

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[32] Joan Arches, "Social Structure, Burnout, and Job Satisfaction," *National Association of Social Workers* 36(3) (May 1991), p. 202.

According to Skinner, a pioneer of Behavioral theory, behavioral theorist are concerned with the behavior of people–what they actually do and say. He also believed that if psychology is to a science, its data must be directly observable and measurable.[33] Behaviorists are also especially interested in how people learn to behave in particular ways, and hence the approach is also termed the Learning Theory. They deem learning to be a process whereby individuals, as a result of their experience, establish an association or linkage between two events. This is called conditioning. The goal of behaviorist is to condition people into giving the desired response and the channel by which a desired response is obtained is by some form of stimuli.

The researcher chose the Behavioral theory because the YCW's learn to behave in particular ways as a result of their experiences, which establishes a linkage between two events. The worker may learn to relate the use of restraints with job satisfaction. When a worker uses non-violent crisis intervention techniques, their ability to control situations that occur in the facility may increase, therefore increasing their level of job satisfaction because the environment is safe for the residents and staff alike.

The researcher chose ecological theory because it focuses on a persons developmental influences, interactions with the environment, changing physical and social settings, and how the entire process is affected by the society in which the settings are embedded.[34] Ecologists are concerned with the relationship between living organisms and all the elements of their environment.

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[33]James W. Vander Zanden, *Human Development,* 5th ed., (United States of America, International Edition: 1993) p. 43.

[34] Ibid., p. 8.

One element that comes with the territory of being a YCW is the presentation of numerous other lives that have been negatively affected by their own environments (family). The YCW has a relationship with all of the children he/she serves, which encompasses all of the positive and negative elements that are present in the lives of the children. This will affect the YCW's environment and cause a change in their life whether it is directly or indirectly. Negative elements such as unruly behavior and/or violent behavior can effect the YCW's environment (e.g. workplace) when techniques to intervene are not in place. This type of behavior may also affect YCW's environment at facilities were interventive techniques are in place, but for the purpose of the researchers hypothesis, the use of this theory will be approached from the angel of non-use of interventive techniques. The non-implication of interventive techniques may decrease a workers job satisfaction if the environment is viewed as unsafe to the worker. This researcher also chose to implement the Crisis theory. In the discussion of the history of crisis intervention, C. P. Ewing draws upon the seminal writing of Caplan to summarize the most common formulation of the crisis state:

> Crisis theory is grounded in the concept of homeostasis. People are continually confronted with situations that threaten to upset the consistent pattern and balance of their emotional functioning. Ordinarily these threats are short lived; the threatening situation is mastered by habitual problem–solving activity. Although the person is in a state of tension furring the period prior to successful mastery, this tension is generally minimal because the period is relatively brief and the person knows from past experience that mastery is forthcoming. In some instances, however; the threat is such that it cannot be readily mastered by resort to habitual problem-solving methods. [35]

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[35] Richard A. Wells, *Planned Short-Term Treatment*, 2nd ed., (United States of America, The Free Press: 1994), p. 27.

In relation to the use or non-use of restraint and seclusion, this researcher chose the crisis theory because restraint and seclusion techniques are utilized by YCW's in crisis situations. Most crisis that warrant restraint techniques are brief and the crisis interventive strategy used is to bring the situation back to a point were more responsible decisions can be made by the adolescent.

In conclusion, all of the before mentioned theories are methods used to understand the stance this researcher has taken in this research study. By using the eclectic approach, the researcher was able to cover issues surrounding the use and non-use of restraint and seclusion as non-violent crisis intervention techniques among adolescents in residential treatment facilities.

Definition of Terms

Confinement =	To keep within bound by limiting or restricting an area.[36]
De-escalation =	To decrease the scope of intensity by using verbal cues.[37]
Job Satisfaction =	When a person has a "happy" feeling; feeling of fulfillment about the place at which they are employed.[38]
Mechanical restraint =	The use of material devises to restrict movement. Such as metal handcuff, or shackles, leather straps, cloth straps, etc.[39]
Non-violent intervention =	A type of therapeutic intervening that will allow the service worker to prevent violence when disruptive behavior has gone too far. It incorporates de-escalation techniques, identifying cues in the disruptive individual, and maintaining a professional bond with the client even if physical restrains are used.[40]
Ostracism =	To exclude from the other residents by discouraging conversation, interaction, and socialization.[41]
Out of Control =	To lack the ability to regulate, direct, or dominate a situation.[42]

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[36] Webster's Dictionary, *Webster's Dictionary*, (Landoll Inc.: 1993), p. 34.

[37] National Crisis Intervention Institute, "Are You and Your Staff Prepared For a Potentially Violent Episode?" *Violence and Crisis Intervention* October 1995 [articleon-line]; available from http://www.execpc.com/~cpi/mhweb.html; Internet; accessed 20 January 1998 p.2.

[38] Webster's Dictionary, *Webster's Dictionary*, (Landoll Inc.: 1993), 112 & 180.

[39] William A. Fisher, M.D., "Restraint and Seclusion: A Review of the Literature," *American Journal of psychiatry* 151(11) (November 1994), p. 1584.

[40] National Crisis Intervention Institute, "Are You and Your Staff Prepared For a Potentially Violent Episode?" *Violence and Crisis Intervention* October 1995 [articleon-line]; available from http://www.execpc.com/~cpi/mhweb.html; Internet; accessed 20 January 1998 p.2.

[41] Webster's Dictionary, *Webster's Dictionary*, (Landoll Inc.: 1993), p. 143.

[42] Ibid., p. 36.

Padded Room =	A room that has padded walls and floors that is used to minimize self-harm and bodily harm to those clients that are in rage.[43]
Physical restraint =	The use of physical maneuvers to restrict movement.[44]
Physical Take-Down =	the physical restraint of a child by at least two people to assist the child who has lost control of behavior to regain control of strong emotions.[45]
Seclusion =	To move, keep apart, or withdraw from others.[46]
Selected Room =	A room that has been chosen by the service worker for the client who is displaying negative behavior.[47]
Therapeutic holding =	The use of physical maneuver to comfortably restrict movement while therapeutic conversation is taking place between the client and the service worker.[48]
Time Outs =	A brief period of rest that allows the client to reflect on negative behavior.[49]
Youth Care Worker =	The primary care taker of the adolescent who serves as a

[43] William A. Fisher, M.D., "Restraint and Seclusion: A Review of the Literature," *American Journal of psychiatry* 151(11) (November 1994), p. 1587.

[44] American Academy of Pediatrics, "The Use of Physical Restraint Interventions for Children and Adolescents in the Acute Care Setting (RE9713)," *Pediatrics* 99 (March 1997), p. 330-335.

[45] Dale J. Barlow, B.S.N., M.H.D., "Therapeutic Holding," *Journal of Psychosocial Nursing* 27(1) (1989) p. 10-14.

[46] Ibid.

[47] Nancy S. Cotton, Ph.D., "Seclusion as Therapeutic Management: An Invited Commentary," *American Journal of Orthopsychiatry* 65(2) (April 1995) p. 245-248.

[48] Dale J. Barlow, B.S.N., M.H.D., "Therapeutic Holding," *Journal of Psychosocial Nursing* 27(1) (1989) p. 10-14.

[49] William A. Fisher, M.D., "Restraint and Seclusion: A Review of the Literature," *American Journal of psychiatry* 151(11) (November 1994), p. 1587.

direct "parent" figure by assisting in taking care of the adolescents basic needs.[50]

Statement of Hypothesis

There will be a significant difference between Youth Workers perception of restraint and seclusion as an interventive strategy among adolescents in residential treatment facilities and the effects they have on job satisfaction.

[50] Kim Snow, "Aggression: Just Part of the Job?" *Journal of Child and Youth Care* 9(4) (1994), p. 11-29.

CHAPTER THREE

METHODOLOGY

Research Design

This is a comparative analysis that was designed to assess job satisfaction among Youth Care Workers and their perception of restraint and seclusion and as an interventive technique among residents in residential treatment facilities. The analysis will determine whether a sample of YCW's, from a local residential treatment facility that uses restraint and seclusion, experience higher levels of job satisfaction than another sample of YCW's from another local residential treatment facility that does not use restraint and seclusion.

Setting

The residential treatment facilities that were used in this study are in the form of cottages and houses.

The facility that does not use non-violent crisis intervention techniques houses their adolescents in cottage type buildings. There are four cottages on the premises and they can hold up to sixteen children each. This agency cares for females only and their staff to resident ratio is 1:8. This agency employs female workers only. There are two to

three children per room and the roommates are selected according to vacancy space and behavior histories.

The facility that does use non-violent crisis intervention houses their residents in homes located in the community. These houses are located all around the metro Atlanta area. There are currently six houses that hold up to six children each. This agency cares for both male and female adolescents. The staff to resident ratio is 1:3. The agency employs both male and female workers. There are normally two children per room and the roommates are also selected according to vacancy space and behavior histories.

Both facilities are designed to give the "homey" feeling and the facilities have all of the amenities of a home, (e.g. telephone, stereo, VCR, video games, computers, etc.). The Youth Care Workers at both facilities have their own bedrooms and bathrooms that are located in the vicinity of the children they are primarily responsible for.

Sample

A non-probability convenience sampling procedure was used to obtain a population of YCW's from two local residential treatment facilities. The only criterion of eligibility was that the participants were YCW's at a residential treatment facility that housed adolescents. The sample size consists of 29 participants, 27 were female and 2 were male. Respondents' ages ranged from 20 to 45. Twenty-seven identified themselves as being of African American origin. The other three identified themselves as being of the European decent.

Data Collection Procedure Instruments

The data was collected through questionnaires that were distributed by the researcher and self-administered by the participants. The questionnaires were administered to the workers at the facility that does not use non-violent interventive techniques on a Friday, which is the scheduled staff meeting day. The turn around time for the questionnaires is approximately 10 minutes. The average length of time for completion of the survey was between 6 to 8 minutes. The researchers reasoning behind personally distributing the questionnaires was to give an introduction, and brief statement regarding the purpose and goals of the study, and to promise that confidentiality and anonymity would be exercised. There was not a time limit placed on the respondents, however the researcher encouraged the workers to complete the questionnaires upon issuance.

The questionnaires were administered to the workers at the facility that does use non-violent intervention techniques by placing them in the individual mailboxes of all the respondents. The instructions indicated that they should placed the completed questionnaires in the large yellow envelope that had the researchers name on it and that the envelope would be retrieved exactly one week from the date the questionnaires were delivered. The delivery date was on the cover sheet of the questionnaire. The turn around time for the workers at the facility that does use non-violent interventive techniques was one week after issuance due to the workers alternating workdays. The researcher wrote a detailed letter to the respondents explaining the purpose of the study

and that strict confidentiality would be adhered to. There were no time limits places on the respondents and the only request was that the survey's were completed by the deadline, which was indicated on the questionnaire. The researcher was either physically present or available to be reached by telephone to answer any questions the respondent's may have had. The respondents were made aware that the information obtained for this study would be treated with confidentiality.

The instruments that were used contained five main sections. The first section of this measuring instrument was designed to gather various types of demographic information. Five category responses were provided and the participants were asked to choose on response that represented the appropriate answer.

The second section focused on worker perceived satisfaction with their jobs. An adapted standardized measuring instrument was used to serve the purpose of this study. This questionnaire was designed to measure the cognitive-judgmental aspect of general life satisfaction and the individual's own judgment of his or her quality of life. Ed Diener, Robert A. Emmons, Randy J. Larsen and Sharon Griffin developed this instrument.[1] The word "life" replaced the word "job" in this instrument. This was done to obtain the YCW's perceived satisfaction with their job. This instrument's internal consistency has been very good and has a mean alpha of .87. The instrument appears to have excellent test-retest reliability with a correlation of .82 for a two-month period, suggesting it is very stable.

[1] Kevin Corcoran, and Joel Fischer, *Measures for Clinical Practice: A Sourcebook.* New York: London, 1987 p. 291.

However, because the survey was adapted, the reliability and validity is not dependable.

YCW's job satisfaction was measured in the third section with J. R. Hackman and G.R. Oldman' "Development of the Job Diagnostic Survey. This survey includes items from one of the most common job satisfaction instrument, which is the Minnisota Satisfaction Questionnaire (MSQ).[2] The survey gives researchers considerable amounts of information about workers attitudes towards their jobs. It measures perceptions of the workplace, rather than actual circumstances. The results may be influenced by the wording of questions and the choice of topics covered by the survey. Moreover, the results may be contaminated by individual attitudes toward other dimensions of the workplace. This survey was used to get an idea of Youth Care Workers' level of job satisfaction. This instrument has a mean alpha of .97, indicating excellent internal consistency, and an excellent (low) Standard Error of Measurement of 3.64. The instrument has excellent known-groups validity, significantly distinguishing between groups of clients designated by themselves and their counselors as having or not having relationship problems with their children. The IPA also has fair construct validity.

In the fourth section an instrument was used to measure restraint and this researcher designed it. There were five closed-ended questions that inquired information on workers perception of restraints. The restraint questions were presented in a situational format, e.g., "When restraint is necessary... and In the use of restraint... This

[2] Ibid.

measurement instrument was not pre-tested; therefore the evidence of reliability or validity is unknown. The measure was developed using this researchers personal knowledge of questions that would be appropriate for both groups. The questions were designed so that the group that does not use restraints could answer the questions based upon their perception.

In the fifth and last section, seclusion was measured with an instrument also designed by this researcher. There were five closed-ended questions that inquired information on workers perception of seclusion. The seclusion questions were presented in a situational format, e.g., "When seclusion is necessary... and In the use of seclusion..." This measurement instrument was not pre-tested, therefore the evidence of reliability or validity is unknown. This measure was also developed using this researchers personal knowledge of questions that would be appropriate for both groups. The questions were designed so that the group that does not use seclusion could answer the questions based upon their perception.

Data Analysis

The statistical test used to analyze data or to measure the variables, YCW's Perceived Satisfaction with their Job, YCW's Job Satisfaction, YCW's Perception of Restraints, and YCW's Perception of Seclusion was the two tailed t-Test. Frequency and percentage distribution was used also. The two-tailed t-Test was used to determine whether the two means were significantly different at a selected probability level. The

strategy of the t-Test is to compare the actual mean difference expected by chance. The t Test involves forming the ratio of these two values. The data obtained in this study were coded into a computer and analyzed by the use of the statistic computer program entitled Statistical package for the Social Science.

CHAPTER FOUR

PRESENTATION OF RESULTS

In this research study, the 2-tailed T-Test was utilized. This test is a parametric hypothesis test that uses the *t* distribution to arrive at a decision; determines if there is a statistically significant difference between the two mean values of the study variables.[1] An alpha level of .05 was used to determine whether to reject or accept the study hypothesis. The study hypothesis states that there will be a significant difference between Youth Care Workers level of job satisfaction and perception of the use and non-use of restraint and seclusion techniques being among adolescents in residential treatment facilities.

The correlated groups t test, also referred to as the paired groups or matched groups test, is used when the research participants in the two samples are connected or matched in some way. In this research, all of the respondents are people who work with adolescents who reside in a residential treatment facility, but the difference is that one group uses non-violent interventive techniques and the other group does not.

The variables being measured in this study are Youth Care Workers perceived job satisfaction, job satisfaction, perception of restraints, and perception of seclusion.

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[1] Robert W. Weinbach and Richard M. Grinnell. Jr., "Statistics for Social Workers," 3rd ed. (New York: Longman Publishers USA, 1995), 238.

TABLE 1. **Demographic information, by age**

AGE	FREQUENCY	PERCENT	CUM PERCENT
20 – 25	12	41.35	79.0
26 – 30	13	44.85	220.2
31 – 35	2	6.88	182.2
36 – 40	1	3.44	96.2
41 – 45	1	3.44	99.6
TOTAL	**29**	**100.0**	

The percentages were rounded off to the nearest tenth.

Table 1. indicates that twelve participants were between the ages of 20 and 25, thirteen were between the ages of 26 and 30, two were between that ages of 31 and 35, one was between the ages of 36 and 40 and one was between the ages of 41 and 45.

TABLE 2. **Demographic information, by ethnic background**

RACE	FREQUENCY	PERCENT	CUM PERCENT
AFRICAN AMERICAN	26	89.7	89.7
WHITE	3	10.3	100.0
TOTAL	**29**	**100.0**	

The percentages were rounded off to the nearest tenth.

Table 2. indicates that there were twenty-six African American and three White American Youth Care Workers that participated in this study. The total number of participants was twenty-nine.[2]

[2] The tables are numbered in accordance with the order of questions in the survey, but only those discussed at length are included in the text; In Appendix D the others will appear, bearing the numbers of the questions addressed: Table 6-43 on pages 56-74.

TABLE 3. **Demographic information, by religion**

RELIGION	FREQUENCY	PERCENT	CUM PERCENT
BAPTIST	14	48.27	48.3
CATHOLIC	3	10.34	58.6
NON-DENOMINATIONAL CHRISTIAN	1	3.44	62.1
AME	2	6.89	69.0
METHODIST	3	10.34	79.3
CHRISTIAN	2	6.89	86.2
NON-DENOMINATIONAL	2	6.89	93.1
NONE	2	6.89	100.0
TOTAL	**29**	**100.0**	

The percentages were rounded off to the nearest tenth.

Table 3. indicates that there were fourteen Baptist, three Catholic, one Non Denominational Christian, two African Methodist Episcopal, three Methodist, two Christian, two Non-Denominational, and two Non-religious participants in this study.

TABLE 4. **Demographic information, by education**

SCHOOL	FREQUENCY	PERCENT	CUM PERCENT
COLLEGE DEGREE	27	93.1	93.1
OTHER	2	6.9	100.0
TOTAL	**29**	**100.0**	

The percentages were rounded off to the nearest tenth.

Table 4. indicates that twenty-seven of the participants had college degrees and the remaining two participants had other types of degrees.

TABLE 5. **Demographic information, by sex**

SEX	FREQUENCY	PERCENT	CUM PERCENT
MALE	2	6.9	6.9
FEMALE	27	93.1	100.0
TOTAL	**29**	**100.0**	

The percentages were rounded off to the nearest tenth.

Table 5. indicates that there were two male Youth Care Workers and twenty seven female Youth Care Workers that participated in this study. The total number of Youth Care Workers was twenty-nine.

TABLE 44. **Use of restraint and seclusion**

USE OF RESTRAINTS AND SECLUSION	FREQUENCY	PERCENT	CUM PERCENT
YES	14	48.3	48.3
NO	15	51.7	100.0
TOTAL	**29**	**100.0**	

The percentages were rounded off to the nearest tenth.

Table 6. indicates that 48.3% of the participants use restraints and seclusion and 51. 7% percent does not use restraints and seclusion.

TABLE 45. **Workers perception of seclusion**

DO YOU USE SECLUSION	NUMBER OF CASES	MEAN	SD	t-VALUE	Df	2 – TAIL SIGNIFICANCE
YES	14	9.7857	1.847	-.34	27	.736
NO	15	10.1333	3.378			

Using the T-Test at .05 level, indicates that there was no statistical difference in Youth Care Workers perception of seclusion between workers who use seclusion and workers who do not use seclusion. The mean difference was -.3476, which indicates that the study hypothesis was rejected.

TABLE 46. **Workers perception of restraint**

DO YOU USE RESTRAINTS	NUMBER OF CASES	MEAN	SD	t-VALUE	Df	2-TAILED SIGNIFICANCE
YES	14	9.2857	2.7300	-2.31	27	.028
NO	15	12.0000	3.505			

Using the T-Test at .05 level, indicates that there was no statistical difference in Youth Care Workers perception of restraints between workers who use restraints and workers who do not use restraints. The mean difference was –2.7143, which indicates that the study hypothesis was rejected.

TABLE 47. **Workers perception of job satisfaction**

DO YOU USE SECLUSION AND RESTRAINTS	NUMBER OF CASES	MEAN	SD	t-VALUE	Df	2- TAIL SIGNIFICANCE
YES	14	18.1429	5.362	1.51	27	.144
NO	15	14.9333	6.065			

Using the T-Test at .05 level, indicates that there was no statistical difference in Youth Care Workers perception of job satisfaction between workers who use restraints and seclusion and workers who do not use restraints and seclusion. The Mean difference is 3.2096, which indicates that the study hypothesis was rejected.

TABLE 48. **Workers job satisfaction**

DO YOU USE SECLUSION AND RESTRAINTS	NUMBER OF CASES	MEAN	SD	t-VALUE	Df	2-TAIL SIGNIFICANCE
YES	14	66.9286	4.795	1.18	27	.247
NO	15	62.8000	12.184			

Using the T-Test at .05 level, indicates that there was no statistical difference in Youth Care Workers level of job satisfaction between workers who use restraints and seclusion and workers who do not use restraints and seclusion. The mean difference was 4.1286, which indicates that the study hypothesis was rejected.

According to the findings, the researcher will have to reject the study hypothesis because there is no significant statistical difference in the job satisfaction levels of YCW's that do or do not use restraint and seclusion as interventive techniques.

CHAPTER FIVE

SUMMARY AND CONCLUSIONS

As previously mentioned the use of restraint and seclusion, as interventive strategies are a widely debated issue among care professionals. The subjects within this study were identified as active Youth Care Workers that are actively employed at a residential treatment facility that cares for adolescents and there ages ranged from 22-42. The majority of the respondents were females that worked in the facility that does not utilize restraint and seclusion.

Unlike the study hypothesis, the findings revealed that there was no statistical difference between Youth Care Workers who use restraint and seclusion and Youth Care Workers who do not use restraint and seclusion level of job satisfaction.

The findings did however show that YCW's who do not use restraint and seclusion techniques had higher mean averages, indicating that their perception of seclusion is lower and that they prefer not to use seclusion techniques more often than those YCW's that were already using seclusion methods. The results also indicated that the YCW's who do not use restraint techniques mean averages were lower, also revealing that they preferred not to use restraint techniques more often than those YCW's that use restraint and seclusion techniques.

Limitations

Because the number of respondents was limited to twenty-nine, the results cannot be generalized to include the total population. The limited number of respondents may also contribute to the lack of significant statistical significance. More subjects may have been helpful in getting a more favorable statistical difference in the YCW's perception of restraint and seclusion and if the use and non-use affect their job satisfaction.

Suggested Research Direction

Further research regarding the use of restraint and seclusion techniques is imperative to the Social Work profession. It is important for the YCW's perception of the use of these techniques be further explored because their comfort level in performing these methods is very important and if they do not feel these intervention techniques are helpful, the need for more research is great.

Perhaps more research investigating the facilities administrative support system for the YCW's who do and do not use these interventive techniques would be helpful. Further research, in regards to the following of protocol guidelines when abusive adolescents continue to violate the rights of the YCW's, should also be investigated. The lack of follow through on the part of administration may contribute to low job satisfaction because the YCW's may feel that they do not have the support they need from administration to ensure safety for themselves and other residents alike.

CHAPTER SIX

IMPLICATIONS FOR SOCIAL WORK

The social work profession manifests itself in almost every realm that deals with the human population. The values and rights of children are always at the forefront of any issue that somehow threatens the welfare of a child. However, what happens when the welfare of the primary care taker (YCW) is threatened and their livelihood is constantly negatively affected by the behavior of the child they are caring for? While society is promoting the need for a better system that cares for children that have been removed from their home for one reason or another, the need for support and understanding of YCW's is also essential.

True enough, it is the social worker's responsibility to advocate for the rights of the child, but in the field of residential treatment, there is also a need for the protection of the adults that care for these children. Behavioral problems are commonly present in this population, which normally warrants aggressive behavior on the child's part. Social workers can assist in helping adolescents understand the issues that are sensitive to them so that unnecessary aggression can be minimized. Social workers may also assist in educating YCW's on the importance of taking care of themselves both physically and psychologically. Meaning, it is sometimes necessary to remove oneself from stressful situations in order to maintain order in one's own life.

Social workers may also serve as a mediator be between YCW's and the adolescents in their care. This can be instrumental because the social worker can be objective and very helpful in allowing both sides to express their feelings about the way a situation was handled.

This study suggests that the Social Work profession can be very helpful in aiding agencies in understand what interventive techniques are most "helpful" when caring for adolescents with behavioral problems. The aim is to improve interventive techniques and provide support to the employees that are caring for the children. The Social Work profession will be equipped to look at the concern from a holistic aspect and that will allow for the development of strategies that will be fair to the workers as well as the children. In relation to the theoretical framework that this study is following, the Social Worker can assist the YCW's in learning how to use non-violent intervention techniques as therapeutic tools, and recognize obstacles that are environmentally based so that the proper treatment plans are implemented.

APPENDIXES

CLARK ATLANTA UNIVERSITY

APPENDIX A.
Letter to the Agency

January 12, 1998

Dear Agency,

As a current employee at this agency, and as a part of my research program in Social Work at Clark Atlanta University, I am seeking information about Youth Care Workers perception of the usage and non-usage of restraint and seclusion as an interventive technique among adolescence in residential treatment facilities and if these techniques affect job satisfaction.

This study is significant because crisis prevention and crisis intervention is a major part of clinical Social Work. It is important that effective interventive and preventive strategies are identified and implemented to better serve the client. I am seeking your permission to use your employees as respondents in my study.

This questionnaire will take about 10-15 minutes to complete. Since I am interested in not just individual responses but the responses of an aggregate of employees, reporting the results will take place on a group level. The name of this agency will not appear in the study and all information acquired by the questionnaires will be treated with confidentiality. The questionnaires will remain in the possession of the researcher. Your employee's participation in this survey is entirely voluntary. You are welcome to ask questions regarding the study and your employees participation in this study. Again, I wish to remind you that your employee's comments will remain strictly confidential. Please contact me at 770-465-0679 to inform me of the position you take on the utilization of your employees in my research study. Thank you.

Sincerely,

Iris S. Waldon

223 James P. Brawley Drive, S.W. • Atlanta, Georgia 30314-4391 • (404) 880-8000

CLARK ATLANTA UNIVERSITY

APPENDIX B.
Letter to the Youth Care Worker

January 12, 1998

Dear Youth Care Worker:

As a part of my research program in Social Work at Clark Atlanta University, I am seeking information about Youth Care Workers perception of the usage and non-usage of restraint and seclusion as an interventive technique among adolescence in residential treatment facilities and if these techniques affect job satisfaction.

This study is significant because crisis prevention and crisis intervention is a major part of clinical Social Work. It is important that effective interventive and preventive strategies are identified and implemented to better serve the client. Your participation is imperative to this study because of the direct "care provider" role that exist between the residents and yourself.

As an active Youth Care Worker, you are asked to complete this questionnaire regarding the subjects mentioned above. This questionnaire will take about 10-15 minutes to complete. Since I am interested in not just individual responses but the responses of an aggregate of employees, reporting the results will take place on a group level. Your name will not appear on the questionnaires. All information acquired by this questionnaire will be treated with confidentiality. The questionnaires will remain in the possession of the researcher. Your participation in this survey is entirely voluntary. You are welcome to ask questions regarding the study and your participation in it. If later you find that you have any questions about the survey, feel free to contact the researcher, Iris S. Waldon at 770-610-8433. Again, I wish to remind you that your comments will remain strictly confidential. Thank you for your assistance and cooperation.

Sincerely,

Iris S. Waldon

223 James P. Brawley Drive, S.W. • Atlanta, Georgia 30314-4391 • (404) 880-8000

APPENDIX C.

QUESTIONNAIRE

I. DEMOGRAPHIC INFORMATION

1. a. Age _____

2. b. Ethnic Background

1. African American 2. White 3. Hispanic 4. Other _____

3. c. Religion _____

4. d. Education 1. High school diploma 2. Some college 3. College degree 4. Other _____

5. e. Sex 1. Male 2. Female

II. WORKERS PERCEIVED SATISFACTION WITH THEIR JOB

Below are five statements that you may agree or disagree. Using the scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

1 = Strongly disagree
2 = Disagree
3 = Slightly disagree
4 = Neither agree nor disagree
5 = Slightly agree
6 = Agree
7 = Strongly agree

_____ 6. In most ways my job is close to my ideal.

_____ 7. The conditions of my job are excellent.

_____ 8. I am satisfied with my job.

_____ 9. So far I have gotten the important things I wanted out of my job.

_____ 10. If I could select another job, I would change almost nothing.

III. WORKERS JOB SATISFACTION SCALE

This questionnaire is designed to measure the degree of job satisfaction you have in your relationship with the residents you work with. It is not a test, so there are no right or wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows:

1 = Rarely or none of the time
2 = A little of the time
3 = Some of the time
4 = Good part of the time
5 = Most of the time

_____ 11. My residents get on my nerves.

_____ 12. I get along well with my residents.

_____ 13. I feel that I can really trust my residents.

_____ 14. I dislike my residents.

_____ 15. My residents are well behaved.

_____ 16. My residents are too demanding.

_____ 17. I feel that temper tantrum behavior is irrational.

_____ 18. I really enjoy my residents.

_____ 19. I have a hard time controlling my residents.

_____ 20. I feel that a worker may prevent the onset of a temper tantrum if he/she perceives the build up anxiety and talks to the resident.

_____ 21. I resent my residents.

_____ 22. I think my residents are terrific.

_____ 23. I hate my residents.

_____ 24. I am very patient with my residents.

_____ 25. I really like my residents.

_____ 26. I like being with my residents.

_____ 27. I feel that the most effective way of dealing with a child in a state of temper tantrum is to hold him/her tight and remove him/her from the group.

_____ 28. I feel violent toward my residents.

_____ 29. I feel very proud of my residents.

_____ 30. I wish my residents were more like others I know.

_____ 31. I just do not understand my residents.

_____ 32. My residents are a real joy to me.

_____ 33. I feel that some children stage a *feigned* (pretend) temper tantrum to get their way.

IV. WORKERS PERCEPTION OF RESTRAINT METHODS

The following questionnaire is designed to measure the workers perception of restraint methods used on the residents you work with. It is not a test, so there are no right or wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows.

1 = Therapeutic holding
2 = Physical take-downs
3 = Mechanical restraints
4 = None

_____ 34. In the use of restraint, which method do you prefer?

_____ 35. When residents become physically assaultive, which method do you feel would be most appropriate?

_____ 36. Which of the above methods do you feel most confident in administering?

_____ 37. In the use of restraint, which method do you consider to be the most

therapeutic?

_____ 38. When using restraint which method do you feel is most appropriate for the population that you serve?

V. WORKERS PERCEPTION OF SECLUSION METHODS

The following questionnaire is designed to measure the workers perception of the use of seclusion on the residents you work with. It is not a test, so there are no right or wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows.

1 = Time out
2 = Confinement to selected room
3 = Confinement to padded room
4 = Ostracism by other residents
5 = None

_____ 39. When a restraint technique has been administered to a out-of-control resident, which type of seclusion do you feel is appropriate?

_____ 40. When seclusion is necessary, which form do you prefer?

_____ 41. Which form of seclusion do you consider to be the most therapeutic?

_____ 42. Which form of seclusion do you feel most confident in using?

_____ 43. When seclusion is necessary, which do you feel is appropriate for the population of residents you serve?

APPENDIX D.

Tables

TABLE 6. **In most ways my job is close to my ideal.**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	Df	2-TAILED SIGNIFICANCE
YES	14	3.4286	1.555	.60	27	.551
NO	15	3.0667	1.668			

The mean difference = .3619

TABLE 7. **The conditions of my job are excellent.**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	df	2-TAILED SIGNIFICANCE
YES	14	3.7143	.994	1.46	27	.155
NO	15	2.9333	1.751			

The mean difference = .7810

TABLE 8. **I am satisfied with my job.**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	df	2-TAILED SIGNIFICANCE
YES	14	3.7143	1.437	1.47	27	.152
NO	15	2.8667	1.642			

The mean difference = .8476

TABLE 9. **So far I have gotten the important things I wanted out of my job.**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	df	2-TAILED SIGNIFICANCE
YES	14	4.2857	1.437	.88	27	.389
NO	15	3.7333	1.907			

The mean difference = .5524

TABLE 10. **If I could select another job, I would change almost nothing.**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	df	2-TAILED SIGNIFICANCE
YES	14	3.0000	1.359	1.30	27	.204
NO	15	2.3333	1.397			

The mean difference = .6667

TABLE 11. **My residents get on my nerves.**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	Df	2-TAILED SIGNIFICANCE
YES	14	3.2857	1.139	-.91	27	.370
NO	15	3.7333	1.163			

The mean difference = -.3810

TABLE 12. **I get along well with my residents.**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	Df	2-TAILED SIGNIFICANCE
YES	14	3.2143	.893	1.43	27	.164
NO	15	3.7333	.961			

The mean difference = -.5190

TABLE 13. **I feel that I can really trust my residents.**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	df	2-TAILED SIGNIFICANCE
YES	14	2.5000	1.160	.82	27	.417
NO	15	2.2000	.775			

The mean difference = .3000

TABLE 14. **I dislike my residents.**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	df	2-TAILED SIGNIFICANCE
YES	14	2.2143	.699	.94	27	.353
NO	15	1.9333	.884			

The mean difference = .2810

TABLE 15. **My residents are well behaved.**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	Df	2-TAILED SIGNIFICANCE
YES	14	3.2857	.825	1.84	27	.077
NO	15	2.6667	.976			

The mean difference = .6190

TABLE 16. **My residents are too demanding.**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	Df	2-TAILED SIGNIFICANCE
YES	14	3.7143	.914	.32	27	.749
NO	15	3.6000	.986			

The mean difference = .1143

TABLE 17. **I feel that temper tantrum behavior is irrational.**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	Df	2-TAILED SIGNIFICANCE
YES	14	4.2143	.426	1.73	27	.096
NO	15	3.6667	1.113			

The mean difference = .5476

TABLE 18. **I really enjoy my residents.**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	df	2-TAILED SIGNIFICANCE
YES	14	3.0714	.730	-.74	27	.464
NO	15	3.3333	1.113			

The mean difference = -.2619

TABLE 19. **I have a hard time controlling my residents.**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	df	2-TAILED SIGNIFICANCE
YES	14	2.2143	.802	.81	27	.423
NO	15	1.9333	1.033			

The mean difference = .2810

TABLE 20. **I feel that a worker may prevent the onset of a temper tantrum if he/she perceives the build up anxiety and talk to the resident.**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	df	2-TAILED SIGNIFICANCE
YES	14	2.7143	.994	-2.53	27	.018
NO	15	3.7333	1.163			

The mean difference = .6286

TABLE 21. **I resent my residents.**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	df	2-TAILED SIGNIFICANCE
YES	14	1.7857	.802	1.30	27	.205
NO	15	1.3333	1.047			

The mean difference = .4524

TABLE 22. **I think my residents are terrific.**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	Df	2-TAILED SIGNIFICANCE
YES	14	2.7143	.611	1.02	27	.315
NO	15	2.4000	.986			

The mean difference = .3143

TABLE 23. **I hate my residents.**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	Df	2-TAILED SIGNIFICANCE
YES	14	1.9286	.730	3.78	27	.001
NO	15	1.1333	.352			

The mean difference = .7952

TABLE 24. **I am very patient with my residents.**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	df	2-TAILED SIGNIFICANCE
YES	14	4.0000	.679	-.18	27	.857
NO	15	4.0667	1.223			

The mean difference = -.0667

TABLE 25. **I really like my residents.**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	df	2-TAILED SIGNIFICANCE
YES	14	3.1429	.663	-.36	27	.719
NO	15	3.2667	1.100			

The mean difference = -.1238

TABLE 26. **I like being with my residents.**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	Df	2-TAILED SIGNIFICANCE
YES	14	2.7143	.914	-.41	27	.683
NO	15	2.8667	1.060			

The mean difference = -.1524

TABLE 27. **I feel the most effective way of dealing with a child in a state of temper tantrum is to hold him/her tight and remove him/her from the group.**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	df	2-TAILED SIGNIFICANCE
YES	14	2.4286	1.284	1.43	27	.164
NO	15	1.8000	1.082			

The mean difference = .6286

TABLE 28. **I feel violent towards my residents.**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	Df	2-TAILED SIGNIFICANCE
YES	14	2.0714	.730	2.95	27	.007
NO	15	1.3333	.617			

The mean difference = .7381

TABLE 29. **I feel very proud of my residents.**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	Df	2-TAILED SIGNIFICANCE
YES	14	3.0000	.555	-1.52	27	.141
NO	15	3.40000	.828			

The mean difference = -.4000

TABLE 30. **I wish my residents were more like others I know.**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	df	2-TAILED SIGNIFICANCE
YES	14	3.6429	.745	2.55	27	.017
NO	15	2.5333	1.457			

The mean difference = 1.1095

TABLE 31. **I just do not understand my residents.**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	df	2-TAILED SIGNIFICANCE
YES	14	2.7143	.726	1.93	27	.065
NO	15	2.0000	1.195			

The mean difference = .7143

TABLE 32. **My residents are a real joy to me.**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	Df	2-TAILED SIGNIFICANCE
YES	14	2.7857	.426	.75	27	.459
NO	15	2.5333	1.187			

The mean difference = .2524

TABLE 33. **I feel that some children stage a feigned (pretend) temper tantrum to get their way.**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	Df	2-TAILED SIGNIFICANCE
YES	14	4.0714	.730	.53	27	.597
NO	15	3.8667	1.246			

The mean difference = .2048

TABLE 34. **In the use of restraint, which method do you prefer?**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	df	2-TAILED SIGNIFICANCE
YES	14	2.4286	1.284	-.22	27	.829
NO	15	2.5333	1.302			

The mean difference = -.1048

TABLE 35. **When residents become physically assaultive, which method do you feel would be most appropriate?**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	df	2-TAILED SIGNIFICANCE
YES	14	1.7857	.579	-1.62	27	.117
NO	15	2.2667	.961			

The mean difference = -.4810

TABLE 36. **Which of the above methods do you feel most confident in administering?**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	df	2-TAILED SIGNIFICANCE
YES	14	2.4286	1.284	.06	27	.952
NO	15	2.4000	1.242			

The mean difference = .0286

TABLE 37. **In the use of restraint, which method do you consider to be the most therapeutic?**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	df	2-TAILED SIGNIFICANCE
YES	14	1.2875	.825	-2.96	27	.006
NO	15	2.6000	1.454			

The mean difference = -1.3142

TABLE 38. **When using restraint, which method do you feel is most appropriate for the population that you serve?**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	df	2-TAILED SIGNIFICANCE
YES	14	1.3571	.487	-2.65	27	.013
NO	15	2.3333	1.291			

The mean difference = -.9762

TABLE 39. **When a restraint technique has been administered to an out-of-control resident, which type of seclusion do you feel is appropriate?**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	df	2-TAILED SIGNIFICANCE
YES	14	1.9286	.267	-1.45	27	.157
NO	15	2.4000	1.183			

The mean difference = -.4714

TABLE 40. **When seclusion is necessary, which form do you prefer?**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	df	2-TAILED SIGNIFICANCE
YES	14	2.0000	.961	1.12	27	.273
NO	15	1.6667	.617			

The mean difference = .3333

TABLE 41. **Which form of seclusion do you consider to be the most therapeutic?**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	df	2-TAILED SIGNIFICANCE
YES	14	1.6429	.929	-.99	27	.333
NO	15	2.0667	1.335			

The mean difference = -.4238

TABLE 42. **Which form of seclusion do you feel most confident in using?**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	df	2-TAILED SIGNIFICANCE
YES	14	2.0714	.730	.48	27	.632
NO	15	1.9333	.799			

The mean difference = .1381

TABLE 43. **When seclusion is necessary, which do you feel is appropriate for the population of residents you serve?**

VARIABLE	NUMBER OF CASES	MEAN	SD	t-VALUE	df	2-TAILED SIGNIFICANCE
YES	14	2.1429	.770	.64	27	.525
NO	15	1.9333	.961			

The mean difference = .2095.

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